NEVADA STATE BOARD OF MEDICAL EXAMINERS

NEWSLETTER

VOLUME 41 ★★★ November 2010

NEW IN THIS ISSUE:

Society and Association Corner

– Clark County Medical Society opines. See pages 9-10.

– State Association provides insight. See pages 10-11.

Guest Author

Health Division Corner

Dr. Tracey Green, State Health Officer, discusses three issues important to all practitioners. See page 14.

Special Report

Child and Family Services

YOU *are a mandatory reporter! Essential child abuse and neglect information for health care providers. See pages 15-17.*

Permits vs. Reports – In-Office Procedures and Sedation

Don't be confused. The Form A and B reporting is NOT part of the new Health Division requirement for permitting of offices using sedation and anesthesia. See page 18.

ALSO IN THIS ISSUE:

COMING IN WINTER ISSUE:

2011 Legislative Session

A REGULATORY BOARD

A regulatory board, such as the Nevada State Board of Medical Examiners, is not an advocacy group and does not have constituents. It has licensees. It serves as an oversight entity on the professions it regulates, limited by what degree of oversight state lawmakers allow. Most importantly, it is to do so in a way that firmly places the interests of the public above the interests of the professions it oversees, as it should be.

Boards know things through their simple existence, and they often have to remain static when they witness something they know as the truth start to get lost. This often places a regulatory board in unenviable situations. When asked to speak, boards give facts and describe reasons why things are what they are. When the facts and reasons are not what the listener wants to hear, a board is often critiqued, and often it is incorrectly inferred that there exists some measure of control over external events inherent in a board that intentionally is not applied. There isn't.

One of the best things a board can do is keep in touch with its licensees to the extent afforded it. I hope that this board is on the right track in doing this. One way I hope to keep this board in touch with our licensees is to not only provide facts and reasons for the board's decision-making, but to offer information about what others are thinking and doing. To that end, we have begun, and will continue in the future, to include in our newsletter written submissions from guest authors, special reports, and opinions and positions from our state medical association and societies, and others. Anyone wishing to respond to an article by any of these entities please do so directly to the author, as the thoughts and opinions expressed should be solely attributed to those parties.

- Douglas C. Cooper, Executive Director

NEW BOARD MEMBER

The Board welcomes Donna A. Ruthe, appointed by Governor Gibbons on July 28, 2010, to serve as a public member of the Board. Ms. Ruthe is the owner and broker of Today's Realty, Inc. in Las Vegas. She replaces Renee West, who was a public member of the Board from July 1, 2007 to August 15, 2010. The Board wishes to thank Ms. West for her service to the citizens of the state of Nevada.

MISSION STATEMENT *

The Nevada State Board of Medical Examiners serves the state of Nevada by ensuring that only well-qualified, competent physicians, physician assistants and respiratory therapists receive licenses to practice in Nevada. The Board responds with expediency to complaints against our licensees by conducting fair, complete investigations that result in appropriate action. In all Board activities, the Board will place the interests of the public before the interests of the medical profession and encourage public input and involvement to help educate the public as we improve the quality of medical practice in Nevada.

** The Mission Statement will be amended on 3 December 2010 to include perfusionists.*

OVERSIGHT OF YOUR BOARD – PART TWO

In the July 2010 Newsletter we discussed some of the many ways the Board is overseen by various agencies and controls. We did so because there is a mistaken belief that boards and commissions in Nevada, not just this Board, have no oversight. This is not true. Here is an update of what continuing oversight has recently occurred:

- The independent outside financial audit, for the period 1 July 2009 to 31 December 2009, was completed and the audit findings published. The findings were discussed in an open Board meeting, in accordance with the Open Meeting Law, on September 10, 2010. The Board did very well. A complete copy of the audit findings is on our website at www.medboard.nv.gov.
- A copy of the most recent audit was delivered to the Legislative Counsel Bureau for the Legislature and the Department of Administration, per statute.
- The National Practitioner Data Bank, US Department of Health and Human Services, conducted a select audit and found the Board compliant (see page 6).
- Three Board members and two Board staff members attended required ethics, administrative proceedings, and Open Meeting Law training at the office of the Attorney General in Carson City and Las Vegas, in September 2010.
- On October 15, the Board appeared before the Legislative Commission's Subcommittee to Review Regulations regarding prescription drugs used to fight obesity, delegation and supervision of medical assistants, and issues regarding PA and RT completion of continuing medical education units (see Regulation Update article).
- An independent performance assessment was completed in August 2010. The assessment was performed by the Administrators in Medicine, an independent national group of medical board executives, with representation from the Federation of State Medical Boards and, at the group's selection, two representatives from our Nevada licensee population: one from southern Nevada and one from northern Nevada. The Nevada physicians participating are not affiliated with the Board, except as active licensees. The results of the performance assessment will be available to the public on 3 December 2010, at our next Board meeting.
- The results from the Public Citizen "watchdog" group survey on our Board's website reported in the last issue has not yet been released. We will report it when it is available.
- Last July nearly all boards and commissions participated in a summit called by the office of the Governor.

And all of this since the July 2010 Newsletter.

REGULATION UPDATE

– *PA and RT failure to provide proof of CME completion*

– *Prohibition on certain drugs used for weight control*

– *Medical Assistants*

As you may recall from previous newsletters, the Board has been in the process of seeking to modify several sections of the Nevada Administrative Code (NAC) by way of the regulatory adoption process. Recently, four of the Board's requested modifications to the NAC were heard in front of the Legislative Commission's Subcommittee to Review Regulations. Of those proposed changes presented to the Subcommittee, three were approved by the Subcommittee and became law immediately thereafter.

Two of the approved regulations relate to physician assistants and practitioners of respiratory care and are intended to add clarifying language to currently existing sections 630.350 and 630.530 of the NAC. The new language indicates that failure to submit proof of completion of the requisite amount of continuing medical education credits or continuing education units by the renewal deadline will result in an automatic suspension of the licensee's medical license.

(Regulation Update cont.)

The third approved regulation called for the complete removal of subparagraph (g) of section 630.230 of the NAC. Language in the previously existing subparagraph limited a licensee's ability to prescribe certain medications, including chorionic gonadotrophic hormones, for the control of weight. With the previous proscriptive language removed, licensees may now use their discretion in determining what medications are appropriate for the control of weight, based upon the collective circumstances.

And finally, the regulation advanced by the Board which was intended to create clarifying language for the delegation and supervision of medical assistants by Board licensees under section 630.230 of the NAC, was not approved by the Subcommittee. Although a degree of support for the proposed regulatory change existed at the hearing, the prevailing consensus of the Subcommittee was that the Board might be premature in its efforts to clarify delegation and supervision of tasks to medical assistants, and if the regulation were to be approved, the Board might be preempting the decision making that should more properly fall to the state legislature. As a result, the law and current policy position of the Board, as they relate to medical assistants, and which have been reported in previous newsletters and press releases, remains unchanged.

MEETING & HOLIDAY SCHEDULES

Remainder of 2010

November 11 – Veterans' Day holiday
November 25-26 – Thanksgiving & family day holidays
December 3 – Board meeting
December 24 – Christmas holiday (observed)
December 31 – New Year's Day 2011 (observed)

2011

January 17 – Martin Luther King, Jr. Day holiday (observed)
February 21 – Presidents' Day holiday (observed)
March 11-12 – Board meeting
May 30 – Memorial Day holiday (observed)
June 10-11 – Board meeting
July 4 – Independence Day holiday
September 5 – Labor Day holiday (observed)
September 9-10 – Board meeting
October 28 – Nevada Day holiday (observed)
November 11 – Veterans' Day holiday
November 24-25 – Thanksgiving & family day holidays
December 2-3 – Board meeting
December 26 – Christmas holiday (observed)

Unless otherwise noted, Board meetings are held at the Reno office of the Nevada State Board of Medical Examiners and videoconferenced to the conference room at the offices of the Nevada State Board of Medical Examiners/Dental Examiners, 6010 S. Rainbow Blvd., Building A, Suite 1, in Las Vegas.

The offices of the Nevada State Board of Medical Examiners will be closed on all holidays listed above.

LICENSING & INVESTIGATIONS

LICENSING STATS

For the year to date, the Board has granted the following total licenses:

- 391 physician licenses
- 105 limited licenses for residency training
- 42 physician assistant licenses
- 118 practitioner of respiratory care licenses
- 25 perfusionist licenses

INVESTIGATIVE COMMITTEE STATS

Investigative Committee A, Year to Date

Total Cases Considered	436
Total Cases Authorized for Filing of Formal Complaint (to be Published)	21
Total Cases Authorized for Peer Review	6
Total Cases Requiring an Appearance	20
Total Cases Authorized for a Letter of Concern	57
Total Cases Authorized for Further Follow-up or Investigation	14
Total Cases Reviewed for Compliance	1
Total Cases Authorized for Closure	317

Investigative Committee B, Year to Date

Total Cases Considered	357
Total Cases Authorized for Filing of Formal Complaint (to be Published)	9
Total Cases Authorized for Peer Review	6
Total Cases Requiring an Appearance	11
Total Cases Authorized for a Letter of Concern	80
Total Cases Authorized for Further Follow-up or Investigation	7
Total Cases Reviewed for Compliance	0
Total Cases Authorized for Closure	263

How to Handle a Request for Response and/or Records

Receiving a letter from the Board indicating that a complaint has been filed against a licensee can understandably be an upsetting experience for any licensee. However, the Board has a statutory mandate to investigate complaints filed with it and oftentimes that requires requesting a response and possibly records from a licensee. Below are some pointers to help licensees appropriately handle these stressful occurrences and to avoid additional issues with the Board.

- If you receive a letter requesting a response to a complaint allegation and/or a request for records, respond in as timely a manner as possible. If you do need an extension of time in which to respond, do not wait until the date the response is due to contact the assigned investigator.
- If you are utilizing an attorney to respond, forward the materials to them as quickly as possible upon receipt.
- If you are requested to provide records to the Board, provide the full record. Do not remove items or assume that certain records are not needed. Licensees create many more problems for themselves by not providing full and complete records when first requested to do so. Medical records, by law, may be disclosed to the Board without notification to, or permission from, the patient at issue in the records.
- Do not react defensively and argue with the assigned investigator. The investigator requesting the response and/or records is not making assumptions about you or the complaint, they are fulfilling the statutory duty of the Board to investigate the complaint and discover the truth.
- If you have any questions regarding a request for a response or records, contact the assigned investigator.

By providing requested information in a timely and complete manner, the investigation of a complaint can be accomplished in a more efficient manner, hopefully resulting in a more timely resolution of the matter for you, the licensee.

Recent Changes to National Practitioner Data Bank Reporting Requirements

Earlier this year, the National Practitioner Data Bank was authorized to expand its data collection. The authorization comes from Section 1921 of the Social Security Act, legislation that now allows the disciplinary records of all allied health care professionals to be accessed by organizations when making decisions regarding employment, affiliation, certification or licensure. Below is a partial reprint of a helpful Fact Sheet on Section 1921 for your review. Please visit http://www.npdb-hipdb.hrsa.gov/ for further information and answers to questions you may have.

National Practitioner Data Bank Healthcare Integrity and Protection Data Bank

FACT SHEET ON SECTION 1921

Background of Section 1921
Title IV of Public Law 99-660, the *Health Care Quality Improvement Act of 1986*, as amended, established the National Practitioner Data Bank (NPDB) as an information clearinghouse to collect and release certain information related to the professional competence and conduct of physicians, dentists, and, in some cases, other healthcare practitioners. Originally the operations of the NPDB were directed only toward collecting and releasing information under Title IV. However, in 1987 Congress passed Public Law 100-93, Section 5 of the *Medicare and Medicaid Patient and Program Protection Act of 1987* (Section 1921 of the *Social Security Act*), authorizing the Government to collect information concerning sanctions taken by State licensing authorities against all healthcare practitioners and entities.

Section 1921 was enacted to provide protection from unfit healthcare practitioners to beneficiaries participating in the *Social Security Act's* healthcare programs and to improve the anti-fraud provisions of these programs.

The Data Banks opened Section 1921 for reporting and querying on March 1, 2010.

Section 1921 expands the information collected and disseminated through the NPDB to include reports on all licensure actions taken against all healthcare practitioners, not just physicians and dentists, as well as healthcare entities. Peer Review Organizations and Private Accreditation Organizations must report any negative actions or findings taken against healthcare practitioners or organizations. Queriers have access to State licensure actions taken against all healthcare practitioners and Section 1921 provides limited querying by Quality Improvement Organizations, Federal and State Healthcare Programs, State Medicaid Fraud Control Units and other law enforcement agencies. Section 1921 also will allow entities new to the NPDB to access Section 1921 data through the NPDB.

Confidentiality of Section 1921 Information
Information reported to the NPDB, including information reported under Section 1921, is considered confidential and shall not be disclosed, except as specified in the NPDB regulations. The Office of Inspector General (OIG), HHS, has been delegated the authority to impose civil money penalties on those who violate the confidentiality provisions of NPDB information.

Persons or organizations who receive information from the NPDB, either directly or indirectly, are subject to the confidentiality provisions and the imposition of a civil money penalty if they violate those provisions.

Eligible Entities
Section 1921 requires each State to adopt a system of reporting to the Secretary of HHS certain adverse licensure actions taken against all healthcare practitioners and healthcare entities by any authority of the State that is responsible for the licensing of such practitioners or entities. Additional information may include any negative action or finding that a State licensing authority, peer review organization, or private accreditation entity has concluded against a healthcare practitioner or healthcare entity.

Entities that may obtain State licensure actions and negative actions or findings concluded against licensed healthcare practitioners and entities reported to the NPDB under Section 1921 are not allowed to obtain information regarding medical malpractice payments or adverse clinical privileges and professional society membership actions on practitioners. The following group of queriers will have access to information reported to the NPDB under Section 1921 only:

- Agencies administering Federal healthcare programs, including private sector entities administering such programs under contract.
- State agencies administering or supervising State healthcare programs.
- Authorities of a State or its political subdivisions responsible for licensing health care entities.
- State Medicaid Fraud Control Units.
- U.S. Attorney General and other law enforcement officials.
- U.S. Comptroller General.
- Utilization and Quality Control Peer Review Organizations (now known as Quality Improvement Organizations).

Organizations that are eligible under Title IV to receive medical malpractice payments or adverse licensure, clinical privileges, and professional society membership actions on practitioners are also eligible to receive Section 1921 data.

(Recent Changes to National Practitioner Data Bank Reporting Requirements cont.)

Section 1921 data is not available to the general public. However, persons or organizations are permitted to request information in a form that does not identify any particular practitioner or entity.

Self-Queries
A healthcare practitioner or entity may self-query the Data Banks at any time by visiting the NPDB-HIPDB Web site at *www.npdb-hipdb.hrsa.gov*. All self-query fees must be paid by credit card. For detailed instructions about self-querying, see the *Fact Sheet on Self-Querying*.

NPDB-HIPDB Assistance
For additional information, visit the NPDB-HIPDB Web site at *www.npdb-hipdb.hrsa.gov*. If you need assistance, contact the NPDB-HIPDB Customer Service Center by email at *help@npdb-hipdb.hrsa.gov* or by phone at 1-800-767-6732 (TDD 703-802-9395). Information Specialists are available to speak with you weekdays from 8:30 a.m. to 6:00 p.m. (5:30 p.m. on Fridays) Eastern Time. The NPDB-HIPDB Customer Service Center is closed on all Federal holidays.

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Nevada Medical Board Compliant in National Practitioner Data Bank Reporting

The Board was audited by the National Practitioner Data Bank regarding compliance in reporting disciplinary actions on Physician Assistants, and found to be compliant, as of 1 October 2010. An audit of our compliance in reporting disciplinary actions on Physicians is as of yet unscheduled, but is expected in 2011. The Nevada Medical Board was also found compliant in mandatory reporting concerning all license types, in the last audit, completed in September 2008. For more information on the Reporting Compliance Status of Government Agencies, please go to: http://www.npdb-hipdb.hrsa.gov/news/temp/reportingCompliance.jsp#nv

Important Reminder Regarding Notification of Address Change, Practice Closure and Location of Records

Pursuant to NRS 630.254, all licensees of the Board are required to "maintain a permanent mailing address with the Board to which all communications from the Board to the licensee must be sent." A licensee must notify the Board in writing of a change of permanent mailing address within 30 days after the change. Failure to do so may result in the imposition of a fine or initiation of disciplinary proceedings against the licensee.

Please keep in mind that the address you provide will be viewable by the public on the Board's website.

Additionally, if you close your practice in Nevada, you are required to notify the Board in writing within 14 days after the closure and for a period of 5 years thereafter, keep the Board apprised of the location of the medical records of your patients.

WHOM TO CALL IF YOU HAVE QUESTIONS

Management:	Douglas C. Cooper, CMBI Executive Director
	Edward O. Cousineau, J.D. Deputy Executive Director
Administration:	Laurie L. Munson, Chief
Investigations:	Pamela J. Castagnola, CMBI, Interim Chief
Legal:	Lyn E. Beggs, J.D., General Counsel
Licensing:	Lynnette L. Daniels, Chief

Nevada HIT Statewide Assessment

Lynn G. O'Mara, MBA, State HIT Coordinator

Thank you to all who participated in the Nevada HIT Statewide Assessment conducted from April 16 through July 6, 2010 to assess the state's current availability and utilization of health information technology. Conducted by the Nevada Department of Health and Human Services (DHHS), it was a joint effort of the Office of Health Information Technology (OHIT) and Nevada Medicaid, with support from HealthInsight, Nevada's Regional Extension Center (REC). The HIT Assessment results will be used to assist DHHS with the development of both the statewide infrastructure for Health Information Exchange (HIE) and the financial incentives program for eligible providers who adopt electronic health records (EHRs) and meet the meaningful use requirements recently announced as part of the ARRA HITECH Act.

Based on federal criteria, the HIT Assessment looked broadly at current EHR adoption and HIE utilization by the provider community at large, planned readiness for future EHR adoption and HIE utilization, and barriers to adoption and use. Although not all Nevada providers and payers participated in the assessment, the statistically reliable sample permitted conclusions to be drawn about general EHR and HIE provider readiness based on the information gleaned through the input from providers, payers and other key stakeholders. The final report is available at: http://dhhs.nv.gov/HIT.htm.

Data gathered from the HIT Assessment provide a baseline status of representative EHR and HIE utilization by Nevada's health care community, identify barriers and obstacles to EHR adoption and HIE utilization, assess stakeholder readiness for further adoption, and are the basis for recommendations that address key barriers.

From the HIT Assessment results, it is clear that while levels of EHR adoption and HIE utilization vary greatly across Nevada's provider community, there is general support for both the concept and value of EHRs and HIE. Providers are interested in understanding, and even adopting, technologies that offer potential benefits such as improved patient-centered care and efficiencies in the delivery and provision of health care. However, they face financial constraints, the need for staff training, concerns regarding operational impacts, and having to use existing systems that have traditionally lacked interoperability and require additional enhancements to meet EHR meaningful use requirements for the EHR Incentive Program. These adoption barriers are compounded by a number of other variables that define the environment and context for health care in Nevada. These include the economic climate, the State budget deficit, an ongoing shortage of health care professionals, and confusion about federal requirements and standards.

Key findings from the HIT Assessment include:

- EHR adoption levels vary by provider type with the large hospitals and large physician practices reporting higher levels of EHR adoption compared to other providers.
- There is a lack of exchange of health information occurring in the Nevada health care system, outside a provider's or stakeholder's network.
- Large hospitals, large networks of providers, and other providers who have advanced their EHR capacity ahead of federal legislation have some level of readiness and capacity to participate in an HIE.
- Providers may have difficulty meeting the proposed meaningful use criteria in a timely manner.
- The average Medicaid patient volume of providers planning to apply for EHR incentives is 28%, which is below the required 30% minimum.
- The most significant barrier to implementing, adopting and enhancing EHRs is cost.
- Providers are overwhelmed by the number of options for EHRs and the effort required to implement or enhance systems within the timelines established at the federal level.
- Providers are hesitant to engage in HIE due to patient privacy and security concerns.

There are many challenges facing Nevada's health care community as it works to implement the complex technological innovations that are part of advancing HIT

(Nevada HIT Statewide Assessment cont.)

and HIE in the State. Next step recommendations to address these challenges include:

- Expand current outreach efforts with stakeholders, particularly regarding the EHR Incentive Program and the assistance available from the REC.
- Conduct visioning and strategic planning with representative stakeholders.
- Take incremental steps toward statewide HIE, in alignment with best practices.

More information can be found online at:

State HIT efforts: http://dhhs.nv.gov/HIT.htm
EHR Incentive Program:
https://dhcfp.nv.gov/EHRIncentives.htm
HealthInsight/REC services:
http://www.healthinsight.org/hcp/hrec/hrec.html

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Results are in From E-Health Study

Justin Luna, HIT Project Manager for Nevada Medicaid EHR Incentive Program

The Division of Health Care Financing and Policy (DHCFP) is working with the Centers for Medicare and Medicaid Services (CMS) during planning efforts for the development of the Nevada Medicaid Electronic Health Record (EHR) Incentive Program. The program will provide incentives to eligible Medicaid providers that demonstrate meaningful use of certified EHR technology.

An important part of the planning process is to obtain feedback from the health care providers within the State about their current uses of health information technology (HIT). The E-Health Study report detailing the results of this effort was recently finalized and provides a baseline of overall statewide readiness for HIT in Nevada's health care community. Feedback was gathered from providers in several different ways. There were approximately 80 stakeholders, primarily consisting of physicians, nurses, and hospital representatives, who participated in 15 scheduled focus groups. A total of 32 one-on-one and group interviews were conducted and there were just over 400 total responses to an online e-health survey.

As a result of the assessment activities, it is clear that Nevada's provider community and other health care stakeholders generally support both the concept and value of EHRs and the exchange of health information. Nearly half of all survey respondents have an EHR (46%) and another 32% of the non-EHR users plan to implement a system within the next five years. Levels of EHR adoption and utilization vary greatly across the provider community. Providers use a broad range of EHR functionality to provide and track clinical care and to support operations, but more sophisticated functions of EHRs are not consistently being used. In addition, little exchange of health information is occurring outside of a provider's or stakeholder's network. The complete landscape assessment report along with additional information about Nevada's HIT planning efforts is available online at https://dhcfp.nv.gov/EHRIncentives.htm.

In addition, CMS published the final rule for the Medicare and Medicaid EHR Incentive Programs on July 28, 2010. This rule provides many of the parameters and requirements for the incentive programs. A copy of the final rule and related documents is accessible through the CMS website: http://www.cms.gov/EHRIncentive Programs. This official website provides up-to-date, detailed information about the incentive programs, including eligibility, certification, meaningful use, and registration.

DHCFP will soon begin development of Nevada's State Medicaid HIT Plan and will be seeking input and cooperation from a variety of providers in the health care community to assist with the development process, primarily through outreach campaigns, visioning sessions, and possibly any systems testing that may be necessary. To join the HIT email distribution list or to get more information about Nevada's HIT planning efforts, please email NevadaHIT@dhcfp.nv.gov.

SOCIETY AND ASSOCIATION CORNER

The opinions expressed in the Society and Association articles are those of the authors, and do not necessarily reflect the opinions of the Nevada State Board of Medical Examiners, its Board members or its staff.

Primum Non Nocere "Do No Harm"

Mitchell D. Forman, D.O., FACR, FACOI, FACP,
President, Clark County Medical Society

A series of articles in the *Las Vegas Sun* by Marshall Allen and Alex Richards titled "Do No Harm" paints a very troubling picture of healthcare in Nevada. Using data developed by the federal Agency for Healthcare Research and Quality, the authors investigate a variety of healthcare parameters by reviewing published billing data. The conclusions from this extensive review and interviews with a variety of sources, particularly consumers, suggests that a culture of medical mediocrity, a lack of transparency in publishing sentinel events, a conflict of interests between hospitals and the physicians they supervise, the influence of lobbyists on the legislative process, the inadequacy of state boards of medical examiners in monitoring, investigating, and disciplining the physicians and other healthcare members in their charge and the unwillingness of individual members of the healthcare profession to report the indiscretions of their colleagues are some of the proposed explanations for the healthcare quality issues in Nevada. These issues are not unique to Nevada. Similar reports describe the healthcare in many other states.

What is more troubling about the articles is the manner in which the authors exploit the "facts" by presenting sensational and distorted case reports that tug at the heartstrings of those who read these accounts. The accounts bring to life the individuals who have presumably been impacted by the incompetent, uncaring or malpractice acts of doctors and the medical profession. It takes the raw data and connects it to people. The media has manipulated the message by presenting large portraits of people, presumably harmed by the medical profession, in advertisements that have little or no written descriptions of the facts surrounding the cases. This was most evident in a full page ad on page 8 of the Monday, September 20, 2010 *Las Vegas Sun*. The pictures attempt to condemn an entire profession. As a practicing physician and educator, I understand the concept of treating people not diseases, and of educating our medical students, residents and allied health professionals about the principles contained in the Hippocratic Oath which espouses the principle..."I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone." The vast majority of the medical profession lives this principle every day and with every patient under their care. In fact, the latest *Las Vegas Sun* article acknowledges that a minority of doctors may be responsible for the majority of reports of inadequate or substandard surgical care. I am not deflecting blame or making light of the individuals harmed. The facts should be investigated impartially and those found to be practicing substandard care should be appropriately educated and disciplined.

What the public, legislators and the media need to understand is that medicine is not a pure science. It is also an art. It suffers from imprecision and from the fact that healthcare providers are human and sometimes make mistakes. Transparency would encourage communicating theses errors to patients and their families because it is the right thing to do. What takes this to a higher level is that it involves people's health, quality of life and their lives. That even one person suffers due to medical mistakes, unexpected complications of their treatment or malpractice is tragic. That it affects people, their families and society in a variety of ways should not be tolerated. But to condemn an entire profession (healthcare system in Nevada) is equally unfortunate.

What this series of articles has done is to bring the issues surrounding healthcare in Nevada out into the open, to be discussed, explored and compared to published standards of quality healthcare, i.e., benchmarks. What is missing from this series of articles is an attempt to explore solutions to the inadequacies of Nevada's healthcare system. I learned long ago that documenting a problem should be balanced with possible solutions. This will require educating the public about their health and what to expect when the healthcare system works properly. It will empower the public to question their healthcare providers about published data. It will require the state medical boards to investigate and appropriately

(Primum Non Nocere "Do No Harm" cont.)

discipline those members whose performance is inadequate or substandard. It will require hospitals to monitor and discipline physicians and healthcare providers who practice substandard healthcare. It will require practicing healthcare providers to report the substandard care of their colleagues because it is the right thing to do and without fear of retribution. It will require legislators to create laws to protect the public's health and limit the influence of lobbyists whose interests conflict with the best interests of the public. It will require the creation of an Academic Health Science Center and collaboration of the private and public sectors, to promote quality patient care, education and research.

My concern with the series "Do No Harm" is that it may "do harm" to the public who fears the healthcare system and who may delay seeking healthcare because of that fear. The media needs to acknowledge "Primum Non Nocere" as should the healthcare profession.

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Nevada Medicine and the Coming Legislature

Larry Matheis, Executive Director, Nevada State Medical Association

The 2011 Legislative Session has all the makings of being a political and policy watershed for the State of Nevada and possibly a disaster. It is also likely to be one of the most challenging sessions ever for Nevada medicine. This column is the first in a series intended to discuss the issues and concerns of physicians about the upcoming Session from the perspective of the Nevada State Medical Association.

For the first time since the 1950s, Nevada faces a declining population. For the first time since the 1960s, Nevada per capita income has declined. Nevada leads the nation in unemployment, foreclosures and percentage of the State budget shortfall. Let's start with the last point, because the others all contribute to the State budget crisis and that crisis is likely to define the 120 day Session that starts February 7th.

A new Governor and the largest Legislative freshman class in 50 years will face adopting a 2-year State budget proposal that must address a $3 billion shortfall between the State revenues and the current budget. For the first time, State agencies have posted their proposed budgets (http://budget.state.nv.us/) to the Governor. Governor Gibbons requested most agencies to draft a budget that cuts 10% from the July, 2010-June, 2011 approved budget. On December 1st, the Nevada Economic Forum (http://www.leg.state.nv.us/Interim/75th2009/Committee/NonLeg/EcForum/?ID=48) will project the revenues they expect will be collected from fees, taxes and other sources over the next couple of years and the Governor then must use those projections and the Agency proposal to construct a budget that will be the starting point for the new Governor and the Legislature.

The largest cuts come in the State's largest budget (outside of K-16), which is the Department of Health and Human Services Budget (http://dhhs.nv.gov/BudgetInfo_FY12-13.htm). After 4 rounds of budget cuts, it isn't surprising that these proposals cut deeply into programs that face higher demand because of the factors listed above, including: Medicaid; mental health services; and health related services for seniors and people with disabilities. At least for now, there are no additional cuts in Medicaid payment for physician services in this proposal. (Deep cuts were made in 2003, when the State adopted the 2002 Medicare fee schedule, which has not been increased since. When the recession started, the State cut obstetrical and pediatric payments by about 40% and in the last round of cuts, slashed anesthesiology payments by over 40%.) There are new proposed cuts in payments to hospitals and skilled nursing facilities, the elimination of personal care services and the elimination of virtually every optional coverage benefit from the State Medicaid program. Nevada's Medicaid program already covers only those people minimally required by federal law. (For example, in 2014 the federal "Affordable Care Act" expands Medicaid to cover every uninsured person up to 133% of the federal poverty level. The Nevada financial eligibility standard is 32% of the FPL.) In spite of the cuts in coverage, the surge in caseloads continues as unemployed and uninsured Nevadans make their way through the paperwork maze to get on these programs. Of course, people without coverage do get sick or injured. Physicians and hospitals will continue to serve them without compensation if only through emergency admissions. The thin line of non-profit organizations and free or low-income clinics, which are already at full capacity, will continue, if they can afford it, to fill the gaps which are growing bigger.

The triage centers (which were created when the State faced a mental health crisis resulting from hospital

emergency departments being filled with patients in need of psychiatric hospital care) would be eliminated and the emergency departments can expect to return to crisis levels (which is also when exhausted physicians, nurses and hospital staffs must fill the gaps caused by the State's decisions). The Southern Nevada Mental Health Court is eliminated and the Reno court is cut by 50%. Again, these are likely visitors to emergency departments or in need of psychiatric hospital care. Unfortunately, beds at those facilities are also being cut.

The list goes on with a common thread of increased demand for medical services with decreased State support for the care that is provided. As painful as the proposed cuts are going to be for many, they will leave the State approximately $1.8 billion short of the current budget. That means that any further cuts will necessarily slash payments for all services (including physician payments), dismantle the thin system of State mental health services (it took a decade to restore all of the cuts to mental health made in the recession of 1992), further reduce all efforts and home based care for seniors or patients with disabilities, reduce State regulatory activities and watch helplessly as demand exceeds access and availability. In addition to more cuts, the discussion will necessarily turn to increasing State revenues. Physicians expect to face a proposed State tax on their services as well as further increases in fees for the various State oversight of facilities and services.

The Nevada State Medical Association is engaged in the budget and revenue discussions and will participate in them throughout the coming months. The aim must be to assure sustainable levels of health care to meet the needs of Nevadans. As all consuming as the State budget crisis seems, the Session will also see attacks on the delicately balanced medical liability laws, proposals for independence from physician oversight of nursing and other licensed health professionals, efforts to define the use of medical assistants and the limits of delegation authority by licensed professionals to unlicensed employees, efforts to revise the health insurance laws to assure transparency of the meaning of coverage and the decisions restricting access to physicians and medical care; numerous proposals to require CMEs on various subjects or additional physician education regarding issues including safe injection and prescribing practices, as well as other new regulatory hurdles for physician practices. In future columns, we'll discuss these and related issues that will face physicians in the 2011 Carson City circus.

SOME IMPORTANT NUMBERS

Boards

Nevada State Board of Dental Examiners
(702) 486-7044 / (800) 337-3926

Nevada State Board of Homeopathic Medical Examiners
(775)324-3353

Nevada State Board of Nursing
(702) 486-5800 / (888) 590-6726 (Licensing)
(775) 687-7700 / (888) 590-6726 (Administration/ Investigations/Discipline)

Nevada State Board of Optometry
(775) 883-8367

Nevada State Board of Oriental Medicine
(702) 837-8921

Nevada State Board of Osteopathic Medicine
(702) 732-2147 / (877) 325-7828

Nevada State Board of Pharmacy
(775) 850-1440 / (800) 364-2081

Nevada State Board of Podiatry
(775) 789-2605

Medical Schools

University of Nevada School of Medicine
(702) 671-2240 (Las Vegas)
(775) 794-6001 (Reno)

Touro University Nevada
(702) 777-8786

Medical Associations/Societies

Nevada State Medical Association
(775) 825-6788

Clark County Medical Society
(702) 739-9989

Washoe County Medical Society
(775) 825-0278

Lack of Bedside Etiquette May Derail the Best Medical Care

Bedside etiquette may help diminish Board complaints. Despite the amount of expertise and time physicians spend in delivering proper medical care, lapses in bedside etiquette may negate the perception of the care delivered and actually generate complaints. The following simple rules, which we all know but at times need to review, can assist in reducing the number of complaints a physician may receive with the Board and also help facilitate patient care:

- Introduce yourself with a handshake to the patient, and to other individuals in the room that may have accompanied the patient.
- Ask these individuals to explain their relationship to the patient if necessary.
- Ask the patient if he/she agrees to discussions occurring concerning his/her medical condition with those individuals present in the room.
- Try to sit down in the room, if the situation permits, at the patient's bedside so that you and the patient are sitting on the same level. This helps the patient feel that you are focused on him/her, aware of his/her concerns and that you are not speaking "down" to the patient.
- Four questions to consider asking when relevant:
  1. What brought you here today? / Why are you here?
  2. What do you think is going on?
  3. What do you expect for me to do and to happen during this visit?
  4. What is your major fear about the symptoms you were experiencing?
- After your interview, explain to the patient the issues you are concerned about, and what your plan is (or what you suggest as a plan).
- Explain to the patient the sequence of tests and/or procedures ordered and their anticipated time frame for completion.
- Ask the patient and the individuals accompanying him/her (those that the patient has agreed can be included in conversations about his/her medical condition) if they have any questions regarding any of the information you have provided them or about what to expect in the future. Ask the individuals accompanying the patient if they need to talk to you about any further matters concerning the patient. This conversation may take place outside of the patient's room as the situation dictates. Finally, ask if there is anything else any of them need before you exit the room.
- Discuss any tests and/or procedure results already performed with the patient and those accompanying the patient, of course with the patient's permission.
- Allow all present to ask questions and express concerns. Address those questions or concerns.
- Clear and explicit written discharge and follow-up instructions should then be provided. Sometimes having the patient or other individuals present repeat what you have advised may be necessary to ensure they understand what has been conveyed.

This is not an exhaustive list of everything that should be a part of a thorough and beneficial encounter for both the patient and physician, but is a good reminder of the fundamental communication that should occur, and which can get lost in the frenetic pace of today's health care. These steps can greatly reduce the potential of complaints to the Board against physicians arising from misunderstandings or lack of full and complete communication between the patient and physician.

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Change of Shift "Turnovers" Can Be Problematic for Physicians

Change of shift "turnover" of patients has become an increasing source of complaints filed with the Board and for malpractice civil suits filed against physicians. Recent journal articles reported that as many as 24% of civil malpractice suits filed in various specialties arose from turnover issues. As medical groups expand and a higher number of patients are passed on to the relieving physician at the end of a shift, problems can arise in communication between the physician being relieved and the relieving physician, affecting the continuity of patient care.

(Change of Shift "Turnovers" Can Be Problematic for Physicians cont.)

The issues related to shift turnover of patients affects many disciplines including, but not limited to hospitalists, internists, intensivists, family physicians, emergency physicians, surgeons, orthopedists, OB/GYNs, and many other disciplines. Below are some safeguards that can be utilized and which may help avoid shift turnover problems.

1. Have a regular designated place and time to meet the relieving physician, whenever possible so that a face-to-face meeting can take place between the exchanging physicians.
2. Allow ample time for questions and note taking when meeting with the relieving physician.
3. Avoid reliance on multiple "transfers" of information regarding the patient to determine what is needed for the patient's care. The more channels patient information must pass through and is "handed down" in regard to what is needed for patient care, tests or procedures that should be ordered, the more room for communication problems and errors.
4. In critical situations it may be advisable to allow the crisis to be resolved by the physician that has been taking care of the patient prior to the physician being relieved, if it can be accomplished in a fairly short time frame rather than have the relieving physician immediately take over care of the patient.
5. It is preferable for patients who have defined encounters in an ER, urgent care, or clinic setting to have their care completed by the physician that started the care whenever possible.
6. For complex patients, it may be advisable to write an immediate plan in the patient's notes and define problematic labs/areas that need to be followed to facilitate the care of the patient by the relieving physician.
7. Whenever a vital/critical test is ordered by the physician to be relieved, it is vital to ensure that the relieving physician is aware of what was ordered, why it was ordered, the approximate time to anticipate the results, and actions needed to be taken upon receipt of the results.
8. Upon receiving calls from nursing staff concerning the condition of a patient who has been turned over with unanticipated problems and/or is experiencing issues different than those described by the physician that was relieved, it is advisable to personally examine the patient yourself as soon as possible in order to familiarize yourself with the patient and to address any of the issues conveyed by nursing staff or any other issues that were not anticipated and/or appreciated by the physician that was relieved.

Checklists can be formulated specific for each practice to aid in "turnovers."

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HEALTH PROFESSIONALS ASSISTANCE PROGRAMS

The Nevada State Board of Medical Examiners currently has memorandums of understanding with the following providers to provide assessment, treatment and/or referral for health professionals in the areas of addictive disease, disruptive behavior, mental impairment, and others.

If you or a colleague are in need of these of services, or need to inquire regarding fees, please contact the organization(s) directly:

Case Management Services of Nevada, Inc. (CMS)
Services available in northern and southern Nevada
Contact: Sandra Lee
Address: 888 West 2nd Street, Suite 200, Reno, NV 89503
Phone: 775-247-3619
E-mail: sandralee595@hotmail.com

LifePath Recovery LLC (LPR)
Services available in northern Nevada
Contact: Murray Brooks, LADC
Address: P.O. Box 919, Carson City, NV 89702
Phone: 775-220-1479
E-mail: murraybrooks1@hotmail.com

Nevada Professionals Assistance Program (NPAP)
Services available in northern and southern Nevada
Contact: Peter A. Mansky, M.D., Executive Medical Director
Address: 9811 W. Charleston Blvd., Suite 2-735, Las Vegas, NV 89117
Phone: 702-521-1398
E-mail: NPAP@Cox.net

Professional Recovery Network (PRN)
Services available in northern and southern Nevada
Contact: Larry Espadero, LADC
Address: Please call for address
Phone: 702-251-1377
E-mail: larry.espadero@psysolutions.com

HEALTH DIVISION CORNER

GUEST AUTHOR

A Reprint From State Health Officer Dr. Tracey D. Green's Newsletter, Vol. 1, Issue 1, October 2010

This is the first issue of regular newsletters that I will be sending out to the physician community. In this first issue, I'll be highlighting three important issues: Immunizations, Handwashing & Death Certificates. Please feel free to contact me with future topics that you want me to address.

Immunizations continue to be our best defense against vaccine preventable diseases. Did you know that CDC estimates fewer than half of health care workers report getting an annual flu shot? Are you up-to-date with your immunizations? Many people equate immunizations to children and often forget that adults also need to keep their immunizations current. With flu season right around the corner, now is the perfect time to get your flu shot. Take a moment and reflect about the last time you received your Tetanus vaccination. Did you get the Tdap vaccine which also protects you against whooping cough and diphtheria? Remember, pertussis is back and we are the first line of defense.

I urge all of you to stay current with your immunizations in order to sustain a healthy workforce.

Handwashing is one of the easiest and most efficient ways to combat the spread of infectious diseases. Yet, surprisingly this doesn't occur as often as it should. It is important to remember that we need to wash our hands prior to and after seeing a patient. Thirty seconds of proper handwashing helps to eliminate pathogens that you may have come in contact with and reduces the spread of disease. There are a lot of useful materials on CDC's website that you can review and download at no cost! Protect yourself and your patients...wash your hands!

Death Certificates

Questions? Contact the Office of Vital Records, Electronic Death Registry System Help Desk: 775.684.4166, or email Rani Reed, rrreed@health.nv.gov

According to state statutes (NRS 440.380) the medical certificate of death must be signed by the physician, if any, last in attendance on the deceased. If the physician will not be available for 48 hours following the death, the associate physician shall complete the death certificate.

The most common mistakes that the Health Division's Office of Vital Statistics sees:

Abbreviations for medical conditions

Cross outs on doctor or cause of death information

Misspellings

Etiology information missing for immediate cause of death (more than just respiratory failure or cardiac arrest – *we need cause of this terminal event*)

Date signed by physician prior to date of death

Missing information on autopsy performed

Missing physician name, license number and address information

Death record not signed within 48 hours of presentation to the doctor

Help us be more efficient with this process so families do not have to wait to provide for their loved ones.

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BOARD OFFICER ELECTIONS

At its September 2010 quarterly meeting, the Nevada State Board of Medical Examiners re-elected Charles N. Held, M.D., a Gardnerville/Minden practicing Pulmonologist, as President, re-elected Benjamin J. Rodriguez, M.D., a practicing Las Vegas Plastic Surgeon, as Vice President, and elected Valerie J. Clark, BSN, RHU, LUTCF, a public member of the Board, as Secretary-Treasurer.

SPECIAL REPORT

HEALTH CARE PRACTITIONERS ARE "MANDATORY REPORTERS"

Reporting Child Abuse and Neglect

***by* Division of Child and Family Services**

The problem and the solution to child abuse lies within your community.

If you believe that a child is in immediate danger from child abuse or neglect, then you should call your local child protection services agency, the crisis call center or 911.

WHAT IS CHILD ABUSE AND NEGLECT?

Child abuse occurs when a child (under the age of 18) suffers a non-accidental physical injury as a result of a direct action by an eligible perpetrator.
Child Neglect: There are 2 forms of child neglect.

1. When an **eligible perpetrator fails to make a reasonable effort to stop someone** from taking a direct action causing the child to suffer a physical injury. For example, mother allows boyfriend to sexually abuse the child, the child is neglected by the mother.
2. When **an eligible perpetrator blatantly disregards his responsibility to provide care** to the child. For example, a two year old who is left home alone for an hour is neglected. Blatant disregard means that an eligible perpetrator has failed to take action that a reasonable person would know is dangerous in that it subjects a child to an imminent, real and substantial risk of harm.

Physical injury is a non-accidental physical injury to a child including, but not limited to, sprains, dislocations, damage to cartilage, bone fractures, intracranial hemorrhage, injury to an internal organ, burns, cuts, lacerations, puncture wounds, bites, permanent or temporary disfigurement, and permanent or temporary loss or impairment of a part of a child's body.

Mental injury (emotional abuse) is an injury to the intellectual or psychological capacity or the emotional condition of a child as evidenced by an observable and substantial impairment of his ability to function. The mental injury must be the result of intense and consistent harmful behavior on the part of the caretaker including but not limited to, behaviors that communicate rejection, are threatening, intimidating, disparaging, or humiliating to the child.

Sexual Abuse includes incest, lewdness with a child, sado-masochistic abuse, sexual assault, statutory sexual seduction, open or gross lewdness, and mutilation of the genitalia of a female child, aiding, abetting, encouraging or participating in the mutilation of the genitalia of a female child, or removal of a female child for purposes of mutilating the genitalia of a child, forcing, allowing or encouraging a child to solicit for or engage in prostitution, to view a pornographic film or literature, to engage in filming, photographing or recording on videotape or posing, modeling, depiction of a live performance before an audience which involves the exhibition of a child's genitals for any sexual conduct with a child.

Sexual Exploitation involves the use of a child, not involving physical contact between the child and perpetrator for the perpetrator's sexual arousal, gratification, advantage, or profit. This includes, but is not limited to: indecent solicitation, explicit verbal enticement, inappropriately engaging a child to participate in sexually explicit conversation in person, by telephone or computer, forcing, encouraging, or permitting a child to solicit or engage in prostitution or the production of child pornography, inappropriately looking at a child's genitalia (and vice versa) for the purpose of sexual arousal or gratification of either person and forcing a child to watch sexual acts for the perpetrator's sexual arousal.

Note: Children who are diagnosed as having contracted a sexually transmitted disease congenitally (at birth) are not considered to be abused.

ARE THERE LAWS AGAINST CHILD ABUSE?

Yes. There are federally mandated requirements of each State to have laws about reporting and investigating child abuse and neglect. This mandate is called the Child Abuse Prevention and Treatment Act (CAPTA), 42 USC Sec. 5101, Title 42, Chapter 67.

(Health Care Practitioners are "Mandatory Reporters" cont.)

The laws in Nevada that protect children incorporate Federal mandates. These laws are called the Nevada Revised Statutes (NRS) Chapter 432B - Protection of Children from Abuse or Neglect. These laws and statutes define child abuse and neglect, who should report, when a report should be made and authorize child protection and law enforcement agencies to investigate reports of alleged child abuse and neglect. More specifically, **NRS 432B.020 and NRS 432B.030.**

WHO SHOULD REPORT?

Any person who has reasonable cause to believe child abuse may be occurring or has occurred may report to a Child Protective Services (CPS) or law enforcement agency. Under NRS 432B.121(1), a person has "reasonable cause to believe" based on known facts or circumstances, events, or conditions that would cause a reasonable person to believe that child abuse has occurred or may be occurring. This must be reported by the person as soon as reasonably practicable to a CPS or law enforcement agency.

Mandated reporters are those persons, who in their professional or occupational capacities, know or have reason to believe that a child has been abused or neglected. Mandated reporters are required to make a report immediately to a CPS or law enforcement agency. This report must be made within 24 hours after there is a reason to believe that a child has been abused or neglected. There are penalties for mandated reporters when a report is not received within the time limit (NRS 432B.240).

Mandated reporters include: physicians, dentists, dental hygienists, chiropractors, optometrists, pediatric physicians, medical examiners, professional or practical nurses, physician assistants, psychiatrists, psychologists, marriage or family therapists, alcohol or drug abuse counselors, other medical services licensed or certified in Nevada; personnel of a hospital or similar institution; coroners; clergymen; social workers; administrators, teachers, librarians or counselors of a school; child care providers or private or public facilities; any person licensed to conduct a foster home; officers or employees of a law enforcement agency or an adult or juvenile probation officer, attorneys under certain circumstances; volunteers for an agency which advises persons regarding child abuse or neglect (NRS 432B.220).

- Immunity from civil or criminal liability extends to every person who in good faith makes a report pursuant to NRS 432B.160.
- A person who knowingly and willfully makes or causes another person to make a false report of child abuse or neglect is guilty of a misdemeanor (NRS 432B.240).

WHEN SHOULD A REPORT BE MADE?

A person must report or act "as soon as reasonably practicable." A report should be made if, in light of all the surrounding facts and circumstances which are known or which reasonably should be known to the person at the time, a reasonable person would act within approximately the same period under those facts and circumstances (NRS 432B.121). A report of suspected child abuse or neglect is only a request for an investigation. The person making the report does not need to prove or provide proof that abuse has or may have occurred. Investigation is the responsibility of the Child Protective Services Agency and/or law enforcement.

If additional incidents of abuse occur after the initial report has been made, make another report.

HOW IS ABUSE REPORTED?

A report may be made by telephone or other means of oral communication, written or electronic communications to the nearest CPS or law enforcement agency.

Contents of the report:
The report must contain the following, if obtainable (NRS 432B.230):

- Name, address, age and sex of child;
- Name and address of the child's parents or other person who is responsible for his care;
- The nature and extent of the abuse or neglect of the child;
- Any evidence of previously known or suspected abuse or neglect of the child or child's siblings;
- The name, address and relationship, if known, of the person who is alleged to have abused or neglected the child;
- Any other information known to the person making the report.

Action upon receipt of the report:
Upon receipt of a report concerning the possible abuse or neglect of a child, an agency which provides protective

services or a law enforcement agency shall immediately initiate an investigation if the report indicates that (NRS 432B.260):

- The child is 5 years of age or younger;
- There is a high risk of or serious harm to the child; or
- The child is dead, is seriously injured or has visible signs of physical abuse.

- In other circumstances, an agency which provides protective services will conduct an evaluation within 3 days and may initiate an investigation within 3 days after the evaluation or make a referral for services if an investigation is not warranted.
- Upon completion of the investigation, the agency shall make a finding that the abusive or neglectful situation was confirmed or substantiated through the investigation; the abusive or neglectful situation was not confirmed or unsubstantiated through the investigation; or the agency was unable to prove or disprove the allegation of abuse or neglect because it was unable to locate the child or the person responsible for the welfare of the child (NAC 432B.170).

To report child abuse or neglect, call:

In Clark County:
Clark County Department of Family Services
Claude I. Howard Children's Center
701 K North Pecos
Las Vegas, NV 89101
(702) 399-0081

In Washoe County:
Washoe County Social Services
350 Center Street
Reno, NV 89501
(775) 785-8600

Rural District Offices
Nevada Division of Child and Family Services

Carson City District Office
1677 Old Hot Springs Road, Building B
Carson City, NV 89706
(775) 687-4943

Fallon District Office
1735 Kaiser Street, Fallon, NV 89406-3108
(775) 423-8566

Lovelock Field Office
535 Western Avenue, Lovelock, NV 89419-0776
(775) 273-7157

Tonopah Field Office
500 Frankie Street, Tonopah, NV 89049-1491
(775) 482-6626

Hawthorne Field Office
1000 C Street, Hawthorne, NV 89415-1508
(775) 945-3602

Silver Springs Field Office
3959 Hwy. 50 SW, Silver Springs, NV 89429
(775) 577-1200

Yerington Field Office
215 Bridge Street, Suite #4
Yerington, NV 89447-3568
(775) 463-3151

Elko District Office
3920 Idaho Street, Elko, NV 89801-4611
(775) 738-2534

Battle Mountain Field Office
145 E. 2nd Street, Battle Mountain, NV 89820-2031
(775) 635-8172 & (775) 635-5237

Ely Field Office
742 Park Avenue, Ely, NV 89301-2798
(775) 289-1640

Winnemucca Field Office
475 W. Haskell, #7, Winnemucca, NV 89445-3781
(775) 623-6555

Pahrump District Office
2280 East Calvada, Ste. 302, Pahrump, NV 89048
(775) 727-8497

Other resources for reporting child abuse or neglect:

(800) 992-5757
Crisis Call Center
(Available 24 hours, statewide)

Division of Child and Family Services Website
www.dcfs.nv.us

To report child abuse online go to:
www.dcfs.nv.us/DCFS_ReportSuspectedChildAbuse.htm

! IMPORTANT REMINDERS!

IN-OFFICE SURGERY REPORTS DUE

Watch for the in-office surgery reporting forms that will be coming to every physician in November. NRS 630.30665 requires that **EVERY** physician **MUST** report to the Board whether he or she performed any in-office procedures in which conscious sedation, deep sedation or general anesthesia were administered. Reports must be received by the Board by **January 15, 2011**.

Form A (green print this year) must be provided by all physicians who administered one of the three levels of sedation in-office in 2010.

Form B (black print this year) must be provided by all physicians who did not administer sedation in-office in 2010.

The reporting requirement set forth in NRS 630.30665 is for the purposes of data collection only and has no relation to NRS 449.442, which requires physician offices offering conscious sedation, deep sedation or general anesthesia to obtain a permit from the Bureau of Health Care Quality and Compliance. Regardless of whether or not you are required to obtain a permit pursuant to NRS 449.442, you **must** complete and return either Form A or Form B by the deadline noted above.

IN-OFFICE ANESTHESIA/SEDATION PERMITS REQUIRED BY NRS 449.442

Many licensees have contacted the Board recently regarding the provisions of NRS 449.442 that went into effect on October 1, 2010, requiring physician offices offering anesthesia services, including general anesthesia, conscious sedation or deep sedation to obtain a permit before offering such services. These permits **are not issued by the NSBME** nor can the NSMBE grant any exemptions to the permit requirements. These permits are issued by the Nevada State Health Division – Bureau of Health Care Quality and Compliance (BHCQC). Information regarding these permits must be obtained through the BHCQC at 775-687-4475 in northern Nevada and 702-486-6515 in southern Nevada.

Although the NSBME has no involvement in the issuance of the permits required by NRS 449.442, should a licensee fail to obtain a permit if required to do so by the BHCQC, disciplinary proceedings may be initiated by this Board pursuant to NRS 630.306(15).

2011 LICENSURE RENEWAL

Online licensure renewal will begin April 4, 2011, for Board licensees, to include Medical Doctors, Physician Assistants and Perfusionists. Further, it is anticipated that Practitioners of Respiratory Care will also be included in this online renewal timeframe, as the Board is currently seeking an amendment to Nevada Administrative Code Section 630.525, which will revise the renewal date for Practitioners of Respiratory Care, and which is both hoped and expected to become law in December of this year.

DON'T SAY YOU DIDN'T KNOW!

In the March 2010 newsletter, a list of licensee reporting obligations was published. However, there still seems to be confusion regarding when a licensee must report certain information to the Board. Below is a reiteration of the events that must be reported to the Board. Failure to make these reports in a timely manner may be grounds for disciplinary actions to be initiated against a licensee.

- Change of permanent mailing address –must be done within 30 days after the change and must be in writing and signed by the licensee.
- Change of office location – must be done in writing prior to beginning practice in the new location.
- Closure of a practice – must be done in writing within 14 days of closure.
- Filing of an action for malpractice against a physician – must be done within 45 days after the physician receives service of a summons and complaint.
- Any claim for malpractice against a physician submitted to arbitration or mediation – must be done within 45 days of the claim being submitted to arbitration or mediation.
- Any settlement, award, judgment or other disposition of any action or malpractice claim – must be done within 45 days after the settlement, award, judgment or other disposition.
- Any sanctions imposed against a physician reportable to the National Practitioner Data Bank – must be done within 45 days of imposition of the sanctions.
- Any criminal action taken (i.e. an arrest) or conviction obtained against a licensee, other than a minor traffic violation, in this State or any other state, or by the Federal Government, a branch of the Armed Forces, or a foreign country – must be made in writing within 30 days of the conviction or criminal action.

For further information regarding any of these reporting requirements, contact the Board legal division.

DISCIPLINARY ACTIONS

DISCIPLINE IMPOSED BY STIPULATION OR BY HEARING

ANTHONY, Layfe, M.D. (9724)
Salt Lake City, Utah

Summary: Revocation of Dr. Anthony's medical license in Utah.

Charges: One count violation of NRS 630.301(3) [disciplinary action taken against his medical license in another state].

Disposition: On September 10, 2010, the Board found Dr. Anthony guilty of violating NRS 630.301(3) and imposed the following discipline against him: (1) revocation of license; (2) reimbursement of the Board's fees and costs of investigation and prosecution.

ATKINS, Marilyn, R.R.T. (RC802)
Las Vegas, Nevada

Summary: Failure to comply with an order of the Board's Investigative Committee to participate in, and remain in compliance with, a drug treatment program; and inability to practice respiratory care with reasonable skill and safety because of use of narcotics.

Charges: One count violation of NRS 630.3065(2)(a) [willful failure to comply with an order of the Board's Investigative Committee]; one count violation of NRS 630.306(1) [inability to practice respiratory care with reasonable skill and safety because of use of narcotics].

Disposition: On September 10, 2010, the Board accepted a Stipulation for Settlement by which it found Ms. Atkins violated NRS 630.3065(2)(a) and NRS 630.306(1) and imposed the following discipline against her: revocation of license, stayed contingent upon compliance with various terms and conditions of 48 months' probation imposed upon her.

BARRY, Yvonne, M.D. (7600)
Las Vegas, Nevada

Summary: Failure to comply with an order of the Board's Investigative Committee to participate in, and remain in compliance with, the PRN-PRN treatment program, writing prescriptions in others' names for her own personal use, self-prescribing a controlled substance, dependency on controlled substances, failure to report arrests in 2003 and 2008 on renewal forms in 2005, 2007 and 2009, and failure to report to the Board an arrest in 2010.

Charges: of NRS 630.3065(2)(a) [willful failure to comply with an order of the Board's Investigative Committee]; one count violation of NRS 630.306(2)(a) [engaging in conduct which is intended to deceive]; one count violation of NRS 630.306(8) [dependency on controlled substances]; one count violation of NRS 630.306(2)(c) [engaging in conduct which is in violation of a regulation adopted by the State Board of Pharmacy]; one count violation of NRS 630.304(1) [obtaining, maintaining or renewing or attempting to obtain, maintain or renew a license to practice medicine by bribery, fraud or misrepresentation or by any false, misleading, inaccurate or incomplete statement]; one count violation of NRS 630.306(12) [failure to report, in writing, within 30 days, criminal action taken against the licensee].

Disposition: On September 10, 2010, the Board accepted a Stipulation for Settlement by which it found Dr. Barry violated NRS 630.3065(2)(a), NRS 630.306(2)(a), NRS 630.306(2)(c) and NRS 630.304(1), and imposed the following discipline against her: (1) revocation of license, stayed contingent upon compliance with various terms and conditions of 48 months' probation imposed upon her. Counts III and VI of the First Amended Complaint were dismissed.

BORROMEO, Salvador, M.D. (8770)
Las Vegas, Nevada

Summary: Alleged malpractice related to Dr. Borromeo's care of a patient.

Charges: One count violation of NRS 630.301(4) [malpractice].

Disposition: On September 10, 2010, the Board accepted a Stipulation for Settlement by which it found that in treating the patient referenced in the Complaint, Dr. Borromeo's associated record keeping was deficient, and therefore a violation of NRS 630.3062(1) [failure to maintain timely, legible, accurate and complete medical records] and imposed the following discipline against him: (1) public reprimand; (2) 10 hours CME regarding the subject of medical record keeping; (3) reimbursement of the Board's fees and costs of investigation and prosecution.

CHOU, Stella, M.D. (11344)
Salt Lake City, Utah

Summary: Malpractice related to Dr. Chou's care of four patients, continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field, and failure to provide adequate supervision of a medical assistant she employed or supervised.

Charges: Four counts violation of NRS 630. 301(4) [malpractice]; one count violation of NRS 630.306(2)(b) [engaging in conduct the Board has determined is in violation of the standards of practice established by regulation of the Board, i.e., NAC 630.230(1)(i)]; one count violation of NRS 630.306(7) [continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians

in good standing practicing in the same specialty or field].

Disposition: On September 10, 2010, the Board accepted a Stipulation for Settlement by which it found Dr. Chou violated NRS 630.301(4), NRS 630.306(2)(b), NAC 630.230(1)(i) and NRS 630.306(7) and imposed the following discipline against her: (1) public reprimand; (2) fine of $10,000 ($2,500 for each count of malpractice); (3) reimbursement of the Board's fees and costs of investigation and prosecution.

GABRIEL, Pamela, M.D. (9405)
Las Vegas, Nevada

Summary: Disciplinary action taken against Dr. Gabriel's medical license in North Carolina.

Charges: One count violation of NRS 630.301(3) [disciplinary action taken against her medical license in another state].

Disposition: On September 10, 2010, the Board accepted a Stipulation for Settlement by which it found Dr. Gabriel violated NRS 630.301(3) and imposed the following discipline against her: (1) public reprimand; (2) comply with all terms of the North Carolina Medical Board Consent Order; (3) reimbursement of the Board's fees and costs of investigation and prosecution.

GUMINA, Antonino, M.D. (9897)
Las Vegas, Nevada

Summary: Engaging in sexual activity with a patient Dr. Gumina was treating.

Charges: One count violation of NRS 630.301(5) [engaging in sexual activity with a patient who is currently being treated by the practitioner].

Disposition: On September 10, 2010, the Board accepted a Stipulation for Settlement by which it found Dr. Gumina violated NRS 630.301(5) and imposed the following discipline against him: (1) public reprimand; (2) fine of $5,000; (3) reimbursement of the Board's fees and costs of investigation and prosecution.

INOCENCIO, Carlos, M.D. (9971)
Las Vegas, Nevada

Summary: Malpractice related to Dr. Inocencio's care of two patients and improper prescribing practices.

Charges: Two counts violation of NRS 630.301(4) [malpractice]; two counts violation of NAC 630.230(1)(l) [writing prescriptions for controlled substances to treat acute pain or chronic pain in a manner that deviates from the guidelines set forth in the *Model Guidelines for the Use of Controlled Substances for the Treatment of Pain* adopted by reference in NAC 630.187].

Disposition: On September 10, 2010, the Board accepted a Stipulation for Settlement by which it found Dr. Inocencio violated NRS 630.306(2)(b) [engaging in conduct the Board has determined is in violation of the standards of practice established by regulation of the Board, i.e., NAC 630.230(1)(i)] and imposed the following discipline against him: (1) public reprimand; (2) fine of $1,500; (3) 10 hours CME regarding the subject of controlled substance prescribing; (4) reimbursement of the Board's fees and costs of investigation and prosecution.

LEWIS, John, M.D. (3940)
Tucson, Arizona

Summary: Disciplinary action taken against Dr. Lewis' medical license in Arizona.

Charges: One count violation of NRS 630.301(3) [disciplinary action taken against his medical license in another state].

Disposition: On September 10, 2010, the Board accepted a Stipulation for Settlement by which it found Dr. Lewis violated NRS 630.301(3) and imposed the following discipline against him: (1) public reprimand; (2) reimbursement of the Board's fees and costs of investigation and prosecution.

ROSENMAN, Michael, M.D. (7991)
Las Vegas, Nevada

Summary: Billing for medical services when not authorized to do so.

Charges: One count violation of NRS 630.305(1)(d) [charging for visits to the physician's office which did not occur or for services which were not rendered or documented in the records of the patient]; one count violation of NRS 630.306(2)(a) [engaging in conduct which is intended to deceive].

Disposition: On September 10, 2010, the Board accepted a Stipulation for Settlement by which it found Dr. Rosenman violated NRS 630.3062(1) [failure to maintain timely, legible, accurate and complete medical records] and imposed the following discipline against him: (1) public reprimand; (2) fine of $2,500; (3) reimbursement of the Board's fees and costs of investigation and prosecution

PUBLIC REPRIMANDS ORDERED BY THE BOARD

SALVADOR BORROMEO, M.D.

September 16, 2010

Salvador Borromeo, M.D.
700 Shadow Lane, Ste. 240
Las Vegas, NV 89106

Dr. Borromeo:

On September 10, 2010, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement proposed between you and the Board's Investigative Committee in relation to the formal complaint filed against you regarding case number 09-12423-1.

In accordance with their acceptance, the Board has entered an **ORDER** as follows: that you are guilty of violating NRS 630.3062(1), that you are to be publicly reprimanded, that within one year of the acceptance of the aforementioned Agreement, you shall complete ten hours of Continuing Medical Education (CME) regarding the subject of medical record keeping, which are to be in addition to any CME requirements that are regularly imposed as a condition of licensure in the state of Nevada, and that you shall reimburse the Board for the costs and expenses incurred in the investigation and prosecution of this case, that amount being $2,725.78.

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought professional disrespect upon you and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Charles N. Held, M.D.
President
Nevada State Board of Medical Examiners

STELLA CHOU, M.D.

September 16, 2010

Stella Chou, M.D.
3687 Choke Cherry Drive
Salt Lake City, UT 84109

Dear Dr. Chou:

On September 10, 2010, the Nevada State Board of Medical Examiners found you committed six (6) violations of the Medical Practice Act of the state of Nevada, more specifically:

That you committed four violations of NRS 630.301(4), malpractice, as defined by NAC 630.040, when you failed to exercise adequate due diligence to assure that preoperative exams were being conducted by qualified persons on the four patients at issue in the Third Amended Complaint.

Further, that you committed one violation of NAC 630.230(1)(i) and NRS 630.306(2)(b), failure to provide adequate supervision of a medical assistant who is employed or supervised by the physician or physician assistant, when you failed to provide adequate supervision to medical assistants who assisted in the care of your patients.

Finally, that you committed one violation of NRS 630.306(7), continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field, when from October 2006 to March 2007, you failed to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field while engaged in practice at Valley Eye Center as averred in the Third Amended Complaint.

As a result of its finding that you violated the Medical Practice Act of the state of Nevada, the Board entered its **ORDER** as follows: That you shall be issued a public reprimand, that you shall pay a fine of $2,500.00 each for counts I through IV of the Third Amended Complaint, for a total of $10,000, and that you shall reimburse the Board the reasonable costs and expenses incurred in the investigation and prosecution of this matter in the amount of $21,914.25.

Accordingly, it is my unpleasant duty as President of the Nevada State Board of Medical Examiners to formally and publicly reprimand you for your conduct which has brought personal and professional disrespect upon you, and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Charles N. Held, M.D.
President
Nevada State Board of Medical Examiners

PAMELA GABRIEL, M.D.

November 4, 2010

Pamela Gabriel, M.D.
2001 S. Rainbow, Suite A
Las Vegas, NV 89146

Dear Dr. Gabriel:

On September 10, 2010, the Nevada State Board of Medical Examiners found you committed one (1) violation of the Medical Practice Act of the state of Nevada, more specifically:

That you committed one violation of NRS 630.301(3) when the state of North Carolina Medical Board publicly reprimanded you on October 16, 2009, which constituted the revocation, suspension, modification or limitation of a license to practice medicine in another jurisdiction.

As a result of its finding that you violated the Medical Practice Act of the state of Nevada, the Nevada State Board of Medical Examiners entered its ORDER as follows: That you shall be issued a public reprimand, that you have complied with all the terms and conditions set forth by the North Carolina Medical Board in its Consent Order which became effective on October 16, 2009, that you shall contact the Compliance Officer of the Board within thirty (30) days of the approval and acceptance of this Agreement in order to provide information regarding the most expeditious method of contacting you, that you shall sign a release of information allowing the Board to communicate with the North Carolina Medical Board regarding your compliance with the terms of the North Carolina Consent Order, that you shall cooperate fully with the Compliance Officer, or any other designated person, in the administration and enforcement of this Agreement, that you shall reimburse the Nevada State Board of Medical Examiners the costs of investigation and prosecution of this matter in the current amount of $574.14, along with the costs to conclude the matter, if any.

Accordingly, it is my unpleasant duty as President of the Nevada State Board of Medical Examiners to formally and publicly reprimand you for your conduct which has brought personal and professional disrespect upon you, and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Charles N. Held, M.D.
President
Nevada State Board of Medical Examiners

ANTONINO GUMINA, M.D.

September 17, 2010

Antonio Gumina, M.D.
3510 E. Tropicana Ave,. Suite K
Las Vegas, NV 89121

Dear Dr. Gumina:

On September 10, 2010, the Nevada State Board of Medical Examiners found you committed one (1) violation of the Medical Practice Act of the state of Nevada, more specifically:

That you committed one violation of NRS 630.301(5), engaging by a practitioner in any sexual activity with a patient who is currently being treated by the practitioner, when you continued to have a sexual relationship with a patient who was under your care at the time.

As a result of its finding that you violated the Medical Practice Act of the state of Nevada, the Board entered its **ORDER** as follows: That you shall be issued a public reprimand, that you shall pay a fine of $5,000.00 and that you shall reimburse the Board the reasonable costs and expenses incurred in the investigation and prosecution of this matter in the amount of $1,607.82.

Accordingly, it is my unpleasant duty as President of the Nevada State Board of Medical Examiners to formally and publicly reprimand you for your conduct which has brought personal and professional disrespect upon you, and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Charles N. Held, M.D.
President
Nevada State Board of Medical Examiners

CARLOS INOCENCIO, M.D.

September 17, 2010

Carlos Inocencio, M.D.
650 N. Nellis Blvd.
Las Vegas, NV 89110

Dr. Inocencio:

On September 10, 2010, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement proposed between you and the Board's Investigative Committee in relation to the formal complaint filed against you regarding case number 09-22388-1.

In accordance with their acceptance, the Board has entered an **ORDER** as follows: that you are guilty of a two-count violation of NRS 630.306(2)(b), that you are to be publicly reprimanded, that within one year of the acceptance of the aforementioned agreement, you shall complete ten hours of Continuing Medical Education (CME) regarding the subject of controlled substance prescribing, which are to be in addition to any CME requirements that are regularly required as a condition of licensure in the state of Nevada, that you are fined in the amount of $1,500.00, and that you shall reimburse the Board for the costs and expenses incurred in the investigation and prosecution of this case, that amount being $6,259.23.

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you

for your conduct which has brought professional disrespect upon you and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Charles N. Held, M.D.
President
Nevada State Board of Medical Examiners

JOHN LEWIS, M.D.

September 17, 2010

John Lewis, M.D.
901 West Las Lomitas Road
Tucson, AZ 85704-2709

Dr. Lewis:

On September 10, 2010, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement proposed between you and the Board's Investigative Committee in relation to the formal complaint filed against you regarding case number 09-5834-1.

In accordance with their acceptance, the Board has entered an **ORDER** as follows: that based upon the previous disciplinary action in the state of Arizona, you are guilty of violating NRS 630.301(3), you are to be publicly reprimanded, and you shall reimburse the Board the costs and expenses incurred in the investigation and prosecution of this case in the amount of $810.87.

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought professional disrespect upon you and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Charles N. Held, M.D.
President
Nevada State Board of Medical Examiners

MICHAEL ROSENMAN, M.D.

November 4, 2010

Michael Rosenman, M.D.
3201 S. Maryland Pkwy, Suite 608
Las Vegas, NV 89109

Dear Dr. Rosenman:

On September 10, 2010, the Nevada State Board of Medical Examiners found you committed (1) violation of the Medical Practice Act of the state of Nevada, more specifically:

That you committed one violation of NRS 630.3062(1) by failing to maintain timely, legible, accurate and complete medical records related to the diagnosis of a patient.

As a result of its finding that you violated the Medical Practice Act of the state of Nevada, the Nevada State Board of Medical Examiners entered its **ORDER** as follows: That you shall be issued a public reprimand, that you shall reimburse the Nevada State Board of Medical Examiners the reasonable costs of investigation and prosecution of this matter in the current amount of $2,940.50, along with the costs to conclude the matter, if any, and that you shall pay a fine of $2,500.00.

Accordingly, it is my unpleasant duty as President of the Nevada State Board of Medical Examiners to formally and publicly reprimand you for your conduct which has brought personal and professional disrespect upon you, and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Charles N. Held, M.D.
President
Nevada State Board of Medical Examiners